

For a psychology of the pathological

by Adolfo Pazzagli*, Paola Benvenuti**

Clinical psychology represents to a certain extent a development compared to the discipline previously called “medical psychology”, in the sense of the scientific area that identifies manifestations of mental pathology observable in the overall functioning of the person and that can essentially be connected to psychiatry. Furthermore, clinical psychology is related to general psychology insofar as at the outset of psychological investigation, it is the standpoint that accentuates interest in the pathology: it can be argued that clinical psychology starts from the pathological to bring it into the normal, while general psychology starts from normality to take the pathological as an extension of its research field. Following this line, therefore, the object of clinical psychology is not only the knowledge of mental functioning, but also the patient in his pathological and normal modes of existing.

Clinical psychology understood in this sense has its roots above all in psychoanalysis and in phenomenological psychology, theoretical approaches that have both modernized the concept of pathological and normal.

Psychoanalysis constitutes a conceptual representation of how the mind functions (Freud, 1922) using a mode of investigating the psychic to which it would be almost impossible to gain access.

The unconscious dimension prevails over consciousness in the mental activity of every subject and psychic phenomena are conceived as an interplay of forces, the expression of goal-oriented tendencies which may work together or against each other, in a dynamic conception of psychic events. It is also a therapeutic method for the treatment of neurotic disorders and represents a sequence of psychological knowledge acquired through the analysis of unconscious psychic processes converging in a new scientific discipline.

Phenomenological psychology has been an important direction in psychological analysis which, through the phenomenological movement, recaptured the opposition to the positivist, organicist approach to the mind. It brought back the issue of subjectivity which had been neglected in favour of the natural sciences. In very schematic terms, it is a form of psychology which adopts, as fundamental elements of its identity, the fact that it is a method for describing and understanding psychological and psychopathological experiences which uses the capacity to analyse the phenomena of consciousness in their appearance, the empathic capacity to identify with the experience of the other, and the principle of the “temporary voluntary suspension of judgement” (epochè), i.e. of “putting into parentheses” our acquired knowledge of the world around us so as to comprehend the essence of the other.

A fundamental role is played by consciousness in that it is the capacity to perceive and express subjective experiences: the object of psychopathology is real, conscious psychic happenings, as Jaspers (1913) said. Therefore phenomenological psychopathology sets out to understand human experiences as cognitive categories, to know people’s particular modalities of experience and expression, and to know the person’s relationship with himself and with the world (Rossi Monti, 2001).

In 1947, Minkowski distinguished psychiatry from clinical psychology and regarded psychiatry like all other branches of medicine. It studies the temporal unfolding of clinical events, subordinating them as far as possible to relations of cause and effect. To do so, it uses symptoms that describe and classify, like delusional ideas, hallucinations, disorders of consciousness, of affectivity, of course including a psychopathology that corresponds to the goals pursued by psychiatry (pathogenesis, aetiology, diagnosis, development, prognosis...), and is also subordinate to psychology in the sense that the “pathos” is traced back, as it usually is in medicine, to a deviation, a deformation, the failure of a function or of a faculty, in other words, to an illness. Such a psychopathology does not neglect the differences existing between a maniac’s groundless ideas of

* Full Professor of Clinical Psychology, Department of Neurological and Psychiatric Sciences, Florence University, Italy.

** Full Professor of Clinical Psychology, Department of Neurological and Psychiatric Sciences, Florence University, Italy.

greatness and those of a paranoid based on the hypertrophy of the Ego or those of a schizophrenic typified by their discordant nature; but in so doing it does not change character. This clinical-descriptive method is adequate for the goals pursued by psychiatry and the discipline shows no particular problems in accepting it.

Of the psychopathological manifestations, the phenomenon of delusion stands out due to its typically “mysterious” character. When faced with delusion we can blame a disorder of judgement, but how can a human being declare with certainty such a false idea, against all evidence, against everything that constantly proves him blindingly wrong? In this delusional conviction there is undoubtedly something more than a simple disorder of the ability to judge, which cannot be interpreted using the concatenation of events over time, insofar as delusion is installed in the present and tries to make its way only on this level.

Clinical psychology, in contrast, was considered by Minkowski the psychology of the pathological, which deals with psychopathological events, in the sense of actual experiences including for instance delusion, seen as a subjective experience and as the nucleus of historical truth; or mania, considered a defence against depression.

This picture necessarily includes a psychopathology, but the “pathos” is not linked to a deviation, but to the understanding of the other’s lived experience in its various shades of normal and pathological. In this sense, the pathological element, the pathos, can be considered more like suffering in the broadest sense of the word, than as an illness, i.e. as forms of “being otherwise”, or qualitative modifications of life leading towards an impoverishment and a narrowing of the form of life in general.

The idea of a “norm”, from this standpoint, does not refer to the normal individual, which is so difficult to define, but to the form of life in general, which contrasts the way every individual moves and develops in his life, integrating himself with it, to the barrier created between one’s life and the experience of “being otherwise” which underlies the psychopathological event.

Clinical psychology is at any rate a subject that is difficult to define: in the sense used by Lagache (1949) it refers to a specifically psychological way of understanding man, whether he be healthy or ill, claiming a status independent from medicine, the natural sciences and philosophy. Etymologically, ‘clinical’ defines the medical activity that is carried out at the patient’s bedside, questioning him on his disorders and symptoms, examining him and observing his body for signs of illness, so as to formulate a diagnosis, a prognosis and a treatment. All of this, in the medical domain, constitutes the basis of psychiatry.

Clinical psychology on the other hand takes man in a general sense as its object, not looking for signs or symptoms of illness. Instead, it tries to understand certain aspects of the person, of his suffering, his malaise, and also of his disorders, independently of whether the person is ill or not, in an in-depth study of individual cases, examining aspects of the personality, conflicts, anxieties and defence mechanisms.

In clinical psychology, therefore, the result of the clinical investigation is the case history, while in psychiatry the result is represented by the formulation of a diagnosis, a prognosis and of a therapy. The clinical psychologist establishes a psychological balance of the subject examined as a result of the particular history at the present moment, and based on this, he evaluates the individual potentialities and the possibility of change. The clinical psychologist’s knowledge naturally derives from the relationship with the patient which must evolve in a stable situation which can be repeated and reproduced (the setting), set up so as to be influenced mainly by the subject’s variables.

The three fundamental assumptions of clinical psychology according to Lagache are the following:

1. It is a dynamic psychology insofar as every human being is in conflict with the world, with others and with himself. The study of the individual’s problem situations is one of the aims of clinical psychology, in that the person who tries to solve his conflicts in a realistic, flexible way can be considered adjusted, while the person who makes his conflicts become the norm, who activates his defence mechanisms in a rigid way that is inadequate to the situation, but is already established within him, is considered maladjusted and even psychopathological.

2. It considers the human being an unfinished entity. It deals with the totality of the reactions of a concrete, complex human being grappling with a situation, and re-locates the normal and pathological behaviour it observes in the dynamic unity of the whole person.

3. It is historical and genetic, in the sense of the study of development in relation to the events. The human being is a totality in development resulting from a previous state of evolution in which,

within certain limits, there are possibilities for development at every moment. The clinical psychologist does not confine himself to drawing up a psychological balance of the subject examined, but assesses the possibilities for change in view of the individual potentialities.

From these premises, Lagache draws out the three great goals of clinical psychology of clinical psychology, i.e. counselling, curing, and educating, which are carried out by means of a specific clinical method that refers to two practices found in medicine and in psychiatry:

- a. the observation of behaviours, both spontaneous and stimulated by tests, i.e. a synchronic procedure,
- b. the clinical conversation, which involves an anamnesis and establishes the subject's significant biography, placing his behaviour in an evolving perspective through which the past clarifies the present.

The scientific value of the clinical method is therefore tied to the acknowledgement, in individual cases, of facts and correlations that may later be checked and generalized with different methods. We share the view of Carli and Paniccia (2005) when, in clinical work, they distinguish on the one hand a psychological process that corrects deficits from, on the other hand, psychological work that fosters growth.

In the case of the correction of a deficit, the position of the psychologist is that of believing he/she has the legitimate authority to intervene in a problematic situation interpreted as differing from a model which is supposedly socially shared and confirmed. The reduction of the deficit is characterized by the following features: it is based on the fact that its aim is the evaluation of the other within the "model/deviation from model" logic, which can be considered an "objective" assessment; it is based on the medical model, assuming any deviation from the model to be illness, and the intervention to correct the deviation to be the cure for the illness; it calls for a diagnostic function that uses standardized categories and that claims to replace the relationship, an indispensable feature of the psychological intervention, with the formulation of a diagnosis. In this type of intervention, the work of the psychiatrist is immediately recognizable, tending to substitute diagnosis for the relationship with the person, in the attempt to overcome the deficit, i.e. mental illness.

Psychological work geared to growth is characterized by a goal entailing the use of individual or organizational resources that can promote the development of the individual-context relationship, and it means that the psychologist knows the context not only of the individual and his inner dynamics, but also the lines of development in social systems. This work does not envisage reference to a pre-established growth model corresponding to a norm, insofar as its typical feature is the continuous negotiation of the directions of development, with the subjects in the individual-context system. Moreover, both in single people and in groups, this intervention involves bargaining on a development plan, in the sense of seeing what resources are present, rather than identifying problems, disorders or deviance, and can also involve the development of single individuals within a project.

It seems that in the intervention promoting development one can recognise the work of the clinical psychologist, based on the relationship with the single subject and on the historicization and contextualization of the individual in relation to the social belonging systems.

A clarification needs to be made on the concept of development, which on the one hand concerns a possible development of the individual correlated to the psychological intervention, or at any rate a potentiality to be wished for, while on the other referring to the consequences of a project either of the individual in his context or of an organization or social system.

From these considerations it can be hypothesized that one of the strengths of clinical psychology, in fact the most significant one, is that of being a "psychology of the pathological". This approach enables one to put aside the model of deficit correction and of the regulatory proposal of intervention, in favour of a model promoting development within a plan which constitutes the meaning of the psychological intervention. It is obvious that from this perspective we must assess the emerging disorder and use standardized diagnostic categories as initial reference points, but also proceed in the search for the subjective, historical, contextual, purposeful meaning of the problem, using the relationship as the favoured tool.

An example seems particularly appropriate to the comments made: delusion, a psychopathological phenomenon crucial as a symptom, but also in the very definition of mental illness, is considered by classical psychopathology to be a disorder of thought, a primary, underivable category

indicating madness, but it can also be interpreted as lived experience and the nucleus of individual historical reality, if one uses a perspective of psychological understanding based on the relationship.

There are many psychopathological definitions of delusion, but they are all only partially satisfactory. For example, delusion has been identified in terms of the falseness of the belief about the shared reality (Jaspers, 1913), but it is obviously very difficult to define the concept of truth; it has been considered an incredible or completely impossible conviction, but such a parameter is clearly not very reliable; it has been underlined that in delusional beliefs there is an absence of cultural support (APA, 1994), but we could then ask how delusional we must consider an extremely innovative but misunderstood genius; the absolute conviction with which the person maintains his beliefs has been highlighted (APA, 1994; Freud, 1911; Jaspers, 1913), but we can ask whether there exists an indestructible certainty or rather fluctuations, levels of conviction that vary according to the moment, the context, the situation. It therefore seems probable that delusion is in fact defined by a set of criteria like those listed which, taken one by one, are indicative but not sufficient to define delusion, and are to be considered present with varying degrees of significance, none of which in itself is sufficient to define the phenomenon of delusion, but are to be seen as aspects of a phenomenon that can be described as a form, a structure, an organization.

A dimensional classification (Kendler, 1983; Strauss, 1969) considers the following points: the balance of proof in favour of or against the belief is such that people consider it completely incredible; the conviction is not shared by others; the conviction is maintained with a feeling of certainty and the declarations and behaviour of the person are not affected by the presentation of compelling counterarguments; the person is emotionally involved in the belief and finds it difficult not to think or talk about it; the belief involves personal aspects rather than beliefs of a scientific, religious, political nature, even if they are unconventional; the belief is a source of subjective suffering or interferes with the subject's social or occupational functioning; the person does not report any subjective attempts to resist the belief.

On the phenomenic-relational level, a delusion can appear in a person's relations in various ways:

- as incomprehensible, bizarre, even threatening or dangerous behaviour, to be interpreted constantly in relation to the relativity of the context (Bateson, 1959),
- as the tale of a personal belief that appears certain and inaccessible, since it is not in a dimension of dialogue, but admits only blind acceptance or global confutation, or as a "fracture of intersubjectivity" (Blakenburg, 1987) in which we can also see a fracture of intrasubjectivity,
- as a tale told by others (such as family members) to whom it has been told or who have witnessed bizarre, incomprehensible behaviour,
- as a combination of the various elements described.

The appearance of a delusion is always accompanied by the perception of the "urgent need to do something", tied to components leading back to the threat and danger of actions connected to the presence of the delusion; to the incomprehensibility and above all to the sense of rejection of relations which pushes towards 'gagging' the delusion in order to restore a dialogue with the patient locked in the dilemma of opposer-believer; to the desire to do something, such as administer antipsychotic drugs, which may be the result of clinical study, but also an attempt to make the delusion disappear or at any rate to separate it from the delusional person and from the relationship with him/her.

Delusion therefore represents a deep-seated conviction in a person with a strong but variable degree of certainty, who has difficulty accepting criticism in relations with others and who locks out intersubjectivity. Outside contestations, which try to confute or remove the delusional belief, probably reinforce defences against doubt, pushing the person even further towards delusion.

For psychoanalysis, which considers delusion to be a projection of psychic ideas that are unbearable for the subject, along with the affections connected to them, the Freudian phrase that the delusional "love their delusion as much as themselves" can be applied, in that, freeing himself from ideas and affections through projection, the subject becomes the only one in possession of this knowledge acquired without opposition. Freud (1924) states "[...] presumably in psychosis the rejected part of reality returns continually to impose itself on psychic life just as the repressed drive does in neurosis". Moreover, the fact that the patient is the only possessor represents a sort of "proof of identity" (Resnik, 2001) for him: "I am the only one who understands, who knows..."

Delusion therefore constitutes a defence, not only because it has freed the subject of unbearable mental contents, but also because “ [...] it has placed itself, like a kind of patch, where originally there was a laceration in the Ego’s relationship with the outside world [...] insofar as the manifestations of the pathogenic process are concealed from those of an attempted healing or reconstruction” (Freud, 1923).

Hence the possibility of interpreting delusion as an extreme means of escaping from doubt. Doubt, even in its etymological roots, reminds us of the idea of ‘double’, of the possibility of an alternative structuring of one’s identity. The possibility for parts of one’s self to be organized in an alternative form gives rise to consciousness and to the subject’s opportunity of self-representation. When the contents found in the other hypothesis of one’s self become unbearable, they can be expelled into the external world, creating a subjectively true reality which, due precisely to this original legitimation, has no need for reality checks.

Summing up, the conviction with which the subject believes in his own delusion seems to get its strength from different components such as the nucleus of historical truth, the reinvestment in a new reality, the sense of revelation solving the problem once and for all, and the extreme defence of these meanings compared to the attacks of the “sane.” Delusion is therefore seen as “revealed truth” which the subject experiences in absolute terms, to a greater or lesser extent, since without it he cannot avoid the perception of catastrophic change (*Wahnstimmung* = catastrophic change, *trema*, homosexual panic) experienced without certainties or anchorages in meaning because of the radical identity problems experienced when relating with his own inner world and therefore also with the outside world.

Questioning the conviction of the delusional subject, showing scepticism, indifference, and also acceptance, only reinforce the dimension of absolute certainty revealed by the delusion. When delusion appears in a relationship, in the form of the tale of the subject or of those that live around him, or as an ‘acting out’ through conduct that finds its justification in the delusion, it appears to be a revelation that interrupts or seriously hinders the narrator-listener relationship, a disturbing element that represents an attack on the relationship and at the same time a call for help that presupposes the taking of sides, either with the believers or with the sceptical enemies.

The analysis of delusion in a psychological perspective therefore reveals it as communication about the world of the person and his way of relating to the external world, and shows, in a dimensional perspective, a great range of meaning that can cover a continuum from normality to pathology. On the one hand, there are the delusions found so often in daily life (Heiman, 1955), concerning only one part of the person, which are experienced calmly and are easy to correct (such as hearing it raining when we are planning to spend a day away from home, or some unfortunate event experienced due to somebody’s lack of good will or at least to fate); on the other hand, there are delusions that end up taking control of the person who suffers and is dominated by them.

References

- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC: Author (trad. it. *Manuale Diagnostico e Statistico dei Disturbi Mentali*, Masson, Milano, 1996).
- Bateson, G. (1959). *Mind and Nature: A necessary unity*. Toronto: Bantam Books (trad. it. *Mente e natura: Un’unità necessaria*, Adelphi, Milano, 1984).
- Blankenburg, W. (1971). *La perte de l’evidence naturelle* [Loss of natural evidence]. Paris: PUF (trad. it. *La perdita dell’evidenza naturale*, Cortina, Milano, 1998).
- Carli, R., Paniccia, R.M. (2005). *Casi clinici: Il resoconto in psicologia clinica* [Clinical cases: the report in clinical psychology]. Bologna: Il Mulino.
- Freud, S. (1911). *Psycho-Analytic Notes on an Autobiographical Account of a Case of Paranoia, Dementia Paranoides*. S.E 12, 3-82 (trad. it. *Osservazioni psicoanalitiche su un caso di paranoia, dementia paranoides, descritto autobiograficamente. Caso clinico del presidente Schreber*. In OSF, vol. 5, Boringhieri, Torino, 1977).
- Freud, S. (1924). *Neurosis and psychosis*, S.E., 19: 149-153 (trad. it. *Nevrosi e psicosi*. In OSF, vol. 9, Boringhieri, Torino, 1977).